Neuvera Brain Health Institute - Patient Consent Form

Authorization and Consent

This form authorizes Neuvera Brain Health Institute and its clinicians to access, use, and disclose my medical information, including EEG results, for the purpose of consultation and treatment. This authorization complies with HIPAA regulations.

Patient Information

Full Name: ____________________________

Date of Birth: ____________________________

Consent for Release of Medical Information

I authorize Neuvera Brain Health Institute to obtain and share my medical records, including EEG results, with referring physicians and other healthcare providers involved in my care.

Consent for Consultation and Treatment

I consent to receive medical consultation and treatment from Neuvera Brain Health Institute clinicians. I understand that treatment will occur in California unless otherwise specified.

Telehealth Consent (if applicable)

I consent to receive medical consultation via telehealth using a HIPAA-compliant platform. I understand that telehealth services are subject to state licensure laws.

Patient Rights

I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken.

Signature: ____________________________ Date: _____________

Printed Name: ____________________________